DECLARATION OF EMERGENCY

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Optional Targeted Case Management Services—Reimbursement

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, has adopted the following rule in the Medicaid Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This emergency rule is in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. and shall be in effect for the maximum period allowed under the Administrative Procedure Act or adoption of the rule, whichever occurs first.

The Bureau of Health Services Financing currently funds case management services to the following specific population groups: 1) mentally retarded or developmentally disabled individuals including developmentally delayed infants and toddlers (termed infants and toddlers with special needs under this emergency rule); 2) pregnant women in need of extra perinatal care (termed high-risk pregnant women under this emergency rule) (limited to the metropolitan New Orleans area); 3) HIV disabled individuals (termed persons infected with HIV under this emergency rule); 4) chronically mentally ill (termed seriously mentally ill individuals - for adults and children/youths with emotional/behavioral disorders under this emergency rule); 5) participants in waivers which include case management as a service; and 6) ventilator-assisted children. The bureau has adopted rules governing case management services as the needs of the population groups for these services became apparent and in accordance with available funding.

There has been a tremendous growth in interest on behalf of the public in providing these services to the Medicaid populations. In addition, as these services have been implemented and governed under specific program regulations over the past five years, the department now seeks to enhance all these services to the optimal level while streamlining their administration. In addition this emergency rule establishes enhanced regulations governing consumer eligibility, provider enrollment, provider standards for participation and payment, and general provisions. The department adopted emergency rules to ensure uniform standards for the quality of the services delivered to these persons with special physical and/or health needs and conditions effective July 22, 1994 and August 13, 1994 (*Louisiana Register*, Volume 20, Numbers 6 and 7). Subsequent emergency rules continued this initiative in force as published in the (*Louisiana Register*, November 20, 1994, Volume 20, Number 11, April 20, 1995, Volume 21, Number 4), August 20, 1995 (Volume 21, Number 8), and November 20, 1995, Volume 21, Number 11. The following emergency rule is being adopted to continue these provisions in force in order to assure that the fragile and vulnerable population groups identified above receive case management services essential to their obtaining needed medical services thereby preventing imminent peril to the health, safety, and welfare. An emergency rule was adopted on October 1, 1995 (*Louisiana Register*, Volume 21, Number 10) and subsequently amended effective March 1, 1996 (*Louisiana Register*, Volume 22, Number 3) which established the reimbursement methodology and regulations governing the payment for these services.

Emergency Rule

Effective March 9, 1996 the Bureau of Health Services Financing adopts regulations governing case management services including consumer eligibility requirements, provider enrollment, provider standards for participation and payment, and general provisions. This emergency rule applies to case management services provided either to targeted population groups or under a waiver program(s) in which case management services are included. This emergency rule governs case management services for the following specific population groups: 1) mentally retarded/developmentally disabled individuals; 2) infants and toddlers with special needs; 3) high-risk pregnant women; 4) persons infected with HIV; 5) seriously mentally ill individuals; and 6) persons in waiver program(s) in which case managements services are included. Services for ventilator-assisted children are terminated as a specific targeted group but these children may be eligible under the other target groups listed above. All case management providers must follow the policies and procedures included in this emergency rule as well as in the Department of Health and Hospitals *Case Management Provider Manual*. Under this rule the term *case management* has the same meaning as the term *family service coordination*. Case management services must be delivered in accordance with all applicable federal and state laws and regulations.

I. Standards of Participation

In order to be reimbursed by the Medicaid Program, a provider of targeted or waiver case management service must comply with all of the requirements listed below. Exceptions may be granted by the secretary on a case-by-case basis based on an assessment of available services in the community.

A. Provider Enrollment Requirements. Case management agencies who wish to provide Medicaid funded targeted or waiver case management services must contact the department to request an enrollment packet

and copy of the *DHH Case Management Provider Manual*. Applicants must indicate the population(s) and the geographical areas they wish to serve. The provider must meet all applicable licensure, general standards for participation in the Medicaid Program and specific provider enrollment and participation requirements for the population(s) to be served. Each enrolling agency must also submit a separate provider agreement (Form PE-50) and Disclosure of Ownership form to DHH for each targeted or waiver population and geographical area (DHH region) the agency plans to serve. Providers of services to the seriously mentally ill must meet the re-enrollment requirements of the Medicaid Program.

Each office site of a case management agency must be enrolled separately. Approval by DHH entitles the agency to provide services in the parishes of that DHH region only. This requirement is applicable to both new providers and existing providers already enrolled. When an agency wishes to provide case management services in a parish in another region and that parish is not contiguous to the parish in which an enrolled office site is located, the agency must establish an office in other region, submit a separate enrollment packet, and receive DHH approval to provide services in that DHH region regardless of the number of case managers providing services in the new region. When there are less than three case managers providing services in a parish in another region and that parish is contiguous to the parish in which an enrolled office site is located, the agency is not required to establish an office in the other region.

In accordance with Section 4118(I) of the Omnibus Budget Reconciliation Act (OBRA) of 1987, Public Law 100-203, the department may restrict enrollment and service areas of agencies that are enrolled in the Medicaid Program to provide case management services to seriously mentally ill and developmentally disabled consumers including infants and toddlers with special needs in order to ensure that the case management providers available to these targeted groups and any subgroups are capable of ensuring that the targeted consumers receive the full range of needed services. Case management agencies must meet the enrollment requirements listed below to be approved for enrollment.

All applicant case management agencies must meet the requirements 1-15 listed below to participate as a case management provider in the Medicaid Program, regardless of the targeted or waiver group served:

1. has demonstrated direct experience in successfully serving the target population and demonstrated knowledge of available community services and methods for accessing them including all of the following:
    a. has established linkages with the resources available in the consumer's community;
    b. maintains a current resource file of medical, mental health, social, financial assistance, vocational, educational, housing and other support services available to the target population; and
    c. demonstrates knowledge of the eligibility requirements and application procedures of federal, state, and local government assistance programs which are applicable to consumers served;
    d. employs a sufficient number of qualified case manager and supervisory staff who meet the skills, knowledge, abilities, education, training, supervision, staff coverage and maximum caseload size requirements described in Section C below;
2. possesses a current license to provide case management/service coordination in Louisiana or written proof of application for licensure;
3. demonstrates administrative capacity to provide all core elements of case management and insure effective case management services to the target population in accordance with licensing and DHH requirements by DHH review of the following:
    a. current detailed budget for case management;
    b. report of annual outside audit by a CPA performed in accordance with generally accepted accounting principles;
    c. cost report by September 30 of each year following 12 months of operation;
    d. provider policies and procedures;
    e. functional organization chart depicting lines of authority; and
    f. program philosophy, goals, services provided, and eligibility criteria that defines the target population or waiver group to be served;
4. assures that all case manager staff is employed by the agency in accordance with Internal Revenue Service (IRS) regulations (including submission of a W-2 form on each case manager). Contracting case manager staff is prohibited. Contracting of supervisors must comply with IRS regulations. Each case manager must be employed 20 hours per week;
5. assures that all new staff satisfactorily complete an orientation and training program in the first 90 days of employment and possess adequate case management abilities, skills and knowledge before assuming sole responsibility for their caseload and each case manager and supervisor satisfactorily complete case management related training on an annual basis to meet at least minimum training requirements described below. The provision and/or arranging of such training is the responsibility of the provider;
6. has a written plan to determine the effectiveness of the program and agrees to implement a continuous quality improvement plan approved by the department;
7. documents and maintains an individual record on each consumer which includes all of the elements described in licensing standards for case management and Section III.A. below;

8. agrees to safeguard the confidentiality of the consumer's records in accordance with federal and state laws and regulations governing confidentiality;

9. assures a consumer's right to elect to receive case management as an optional service and the consumer's right to terminate such services;

10. assures that no restriction will be placed on the consumer's right to elect to choose a case management agency, a qualified case manager, and other service providers and change the case management agency, case manager and service providers consistent with Section 1902(a)(23) of the Social Security Act;

11. if currently enrolled as a Medicaid case management provider, assures that case managers will not provide case management and Medicaid reimbursed direct services to the same consumer(s). If enrolled as a case management provider assure that the agency will not provide case management and other Medicaid reimbursed direct services to the same consumers.

12. has financial resources and a financial management system capable of:

a. adequately funding required qualified staff and services;

b. providing documentation of services and costs;

c. complying with state and federal financial reporting requirements; and

d. submitting reports in the manner specified by Medicaid;

13. maintains a written policy for intake screening, including referral criteria:

14. maintains a written policy for transition and closure;

15. with the consumer's permission, agrees to maintain regular contact with, share relevant information and coordinate medical services with the consumer's primary care or attending physician or clinic;

16. fully complies with the Code of Governmental Ethics.

Applicants must meet the following additional enrollment requirements for specific target groups:

17. has a working relationship with a local inpatient hospital and a 24-hour crisis response system (applicable to seriously mentally ill case management only);

18. demonstrates the capacity to participate and agrees to participate in the Case Management Information System (CAMIS) and provide up-to-date data to the regional office on a monthly basis via electronic mail (applicable to seriously mentally ill, infants and toddlers with special needs, and developmentally disabled children 3 years and older and adults only). CAMIS and electronic mail software will be provided without charge to the provider;

19. has demonstrated successful experience with delivery and/or coordination of services for pregnant women; Has a working relationship with a local obstetrical provider/acute care hospital providing deliveries for 24-hour medical consultation; has a multi-disciplinary team consisting, at a minimum, of: a physician, primary nurse associate or CNM; registered nurse; social worker; and nutritionist; all team members must meet DHH licensure and perinatal experience requirements (applicable to high risk pregnant women only);

20. satisfactorily complete a one-day training provided by the Delta Region AIDs Education and Training Center (applicable to HIV infected).

An enrolled case management provider must re-enroll requesting a separate Medicaid provider number and is subject to the above-described enrollment requirements and procedures in order to provide case management services to an additional target population.

Applicants will be subject to review by DHH to determine ability and capacity to serve the target population and a site visit to verify compliance with all provider enrollment requirements prior to a decision by the Medicaid Program on enrollment as a case management provider or at any time subsequent to enrollment. Enrolled case management providers will be subject to review by the DHH and the U.S. Department of Health and Human Services to verify compliance with all provider enrollment requirements at any time subsequent to enrollment.

If the applicant agency is determined to be eligible for enrollment, the agency will be notified in writing by the Medicaid Program of the effective date of enrollment and the unique Medicaid case management provider number for each office site and targeted or waiver group. If the department determines that the applicant case management agency does not meet the general or specific enrollment requirements listed above, the applicant agency will be notified in writing of the deficiencies needing correction. The applicant agency must submit appropriate documentation of corrective action taken. If the applicant agency fails to submit the required documentation of corrective action taken within 30 days of the notice, the application will be rejected. If the case management agency does not meet all of the requirements 1-14 in Section A above, the applicant agency will be ineligible to provide case management services to any targeted or waiver group.

II. Standards of Payment

In order to be reimbursed by the Medicaid Program, an enrolled provider of targeted or waiver case management service must comply with all of the requirements listed below. Exceptions may be granted by the secretary on a case-by-case basis based on an assessment of available services in the community.

A. Staff Coverage. All case managers must be employed by the case management agency a minimum of 20 hours per week and work at least 50 percent of the time during normal business hours (8 a.m. to 5 p.m., Monday through Friday). Contracting of case manager staff is prohibited. Case management supervisors must be employed a minimum of eight hours per week for each full-time case manager (four hours a week

for each part-time case manager) they supervise and maintain on-site office hours at least 50 percent of the time. A supervisor must be continuously available to case managers by telephone or beeper at all other times when not on site when case management services are provided. The provider agency must ensure that case management services are available 24 hours a day, seven days a week.

B. Staff Qualifications. Each Medicaid enrolled provider must ensure that all staff providing targeted case management services have the skills, qualifications, training and supervision in accordance with licensing standards and the department requirements listed below. In addition, the provider must maintain sufficient staff to serve consumers within mandated caseload sizes described below:

1. Education and Experience for Case Managers. All case managers hired or promoted must meet all of the following minimum qualifications for education and experience:

a. a bachelor's degree in a human service-related field such as psychology, education, rehabilitation counseling, or counseling from an accredited institution; AND one year of paid experience in a human service-related field providing direct consumer services or case management in the human service-related field; OR

b. a licensed registered nurse; AND one year of paid experience as a registered nurse in public health or a human service-related field providing direct consumer services or case management in the human service-related field; OR

c. a bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education;

d. thirty hours of graduate level course credit in the human service-related field may be substituted for the year of required paid experience.

The above general minimum qualifications for case managers are applicable for all targeted and waiver groups. Additional qualifications for specific targeted or waiver groups are delineated below:

High Risk Pregnant Women. Each Medicaid enrolled provider must ensure that all case managers providing targeted case management services to high risk pregnant women meet the following qualifications:

a. a bachelor's degree in a human service-related field such as psychology, education, rehabilitation counseling, or counseling from an accredited institution; AND one year of paid experience in a human service-related field providing direct consumer services or case management in the human-service-related field; AND demonstrated knowledge about perinatal care;

b. a licensed registered nurse; AND one year of paid experience as a registered nurse in public health or a human service-related field providing direct consumer services or case management in the human service-related field; AND demonstrated knowledge about perinatal care; OR

c. a bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education; AND demonstrated knowledge about perinatal care; OR

d. a registered dietician; AND one year of paid experience in providing nutrition services to pregnant women.

Developmentally Disabled Waiver Participants. Each Medicaid enrolled provider of case management services to developmentally disabled under the waiver must ensure that all case managers have a minimum of one year of paid post-degree experience working directly with persons with mental retardation or developmentally disabilities.

2. Education and Experience for Case Management Supervisors. A case management supervisor hired or promoted or any other individual supervising case managers must meet all of the education and experience requirements listed below. Staff supervising case management for high risk pregnant women and individuals with acquired head injuries must meet the same qualifications as the case managers for these populations:

a. a master's degree in psychology, nursing, counseling, rehabilitation counseling, education (with special education certification), occupational therapy, speech therapy or physical therapy from an accredited institution; AND two years of paid post-bachelor's degree experience in a human service-related field providing direct consumer services or case management in the human service-related field; one year of this experience must be in providing direct services to the target population to be served; OR

b. a bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education; AND two years of paid post-bachelor's degree experience in a human service-related field providing direct consumer services or case management in the human service-related field. One year of this experience must be in providing direct services to the target population to be served; OR

c. a licensed registered nurse AND three years of paid post-licensure experience as a registered nurse in public health or a human service-related field providing direct consumer services or case management in the human service-related field. Two years of this experience must be in providing direct services to the target population to be served; OR

d. a bachelor's degree in a human-service-related field such as psychology, education, rehabilitation counseling, or counseling from an accredited institution; AND four years of paid post-bachelor's degree experience in a human-service-related field providing direct consumer services or case management in the human-service-related field; Two years of this experience must be in providing direct services to the target population to be served;

e. thirty hours of graduate level course credit in the human-service-related field may be substituted for one year of required paid experience.

The above general minimum qualifications for case management supervisors are applicable for all targeted and waiver groups. Additional qualifications for specific targeted or waiver groups are delineated below:

High Risk Pregnant Women. Each Medicaid enrolled provider must ensure that all case management supervisory staff for high risk pregnant women meet the following qualifications:

a. a bachelor's degree in a human-service-related field such as psychology, education, rehabilitation counseling, or counseling from an accredited institution; AND four years of paid post-bachelor's degree experience in a human-service-related field providing direct consumer services or case management in the human-service-related field; two years of this experience must be in providing direct services to the target population to be served; AND demonstrated knowledge about perinatal care;

b. a licensed registered nurse; AND three years of paid post-bachelor's degree experience in a human-service-related field providing direct consumer services or case management in the human-service-related field; two years of this experience must be in providing direct services to the target population to be served; AND demonstrated knowledge about perinatal care; OR

c. a bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education; AND two years of paid post-bachelor's degree experience in a human-service-related field providing direct consumer services or case management in the human-service-related field. One year of this experience must be in providing direct services to the target population to be served; AND demonstrated knowledge about perinatal care; OR

d. a registered dietician; AND three years of paid post-bachelor's degree experience in a human-service-related field providing direct consumer services or case management in the human-service-related field; two years of this experience must be in providing direct services to pregnant women.

3. Requisite Knowledge, Skills and Abilities. Each Medicaid enrolled provider must look for the following knowledge, skills and abilities in hiring case management staff and must ensure that all staff providing targeted or waiver case management services possess the following basic knowledge, skills, and abilities prior to assuming full caseload responsibilities:

a. Knowledge:
   (1) community resources;
   (2) medical terminology;
   (3) case management principles and practices;
   (4) consumer rights;
   (5) state and federal laws for public assistance;

b. Skills:
   (1) time management;
   (2) assessment;
   (3) interviewing;
   (4) listening;

c. Abilities:
   (1) preparing service plans;
   (2) coordinating delivery of services;
   (3) advocating for the consumer;
   (4) communicating both orally and in writing;
   (5) establishing and maintaining cooperative working relationships;
   (6) maintaining accurate and concise records;
   (7) assessing medical and social aspects of each case and formulating service plans accordingly;
   (8) problem solving;
   (9) remaining objective while accepting the consumer's lifestyle.

4. Training. Case manager and supervisor training must be provided by or arranged by the case manager's employer at the employer's expense.

Training for New Case Managers. Orientation of at least 16 hours must be provided to all staff, volunteers, and students within one week of employment which must include, at a minimum:

a. provider policies and procedures;
b. Medicaid/Program Office policies and procedures;
c. confidentiality;
d. documentation in case records;
e. consumer rights protection and reporting of violations;
f. consumer abuse and neglect policies and procedures;
g. professional ethics;
h. emergency and safety procedures;
i. data management and record keeping;

j. infection control and universal precautions;
k. working with the target population.

A minimum of eight hours of the orientation training must cover orientation on the target population including but not limited to specific service needs and resources. In addition to the required 16 hours of orientation, all new employees with no documented required experience and training must receive a minimum of 16 hours of training during the first 90 calendar days of employment which is related to the target population served and specific knowledge, skills, and techniques necessary to provide case management to the target population. This training must be provided by an individual with demonstrated knowledge of the training topics and the target population. This training must include the following at a minimum:

a. assessment techniques;
b. service planning;
c. resource identification;
d. interviewing and interpersonal skills;
e. data management and record keeping;
f. communication skills.

Annual Training. A case manager must satisfactorily complete 40 hours of case-management related training annually which may include training updates on subjects covered in orientation and initial training. For new employees, the 16 hours of orientation training are not included in the 40-hour minimum annual training requirement. The 16 hours of training for new staff required in the first 90 days of employment may be part of this 40-hour minimum annual training requirement. Appropriate updates of topics covered in orientation and training for a new case manager must be included in the required 40 hours of annual training. The following is a list of suggested additional topics for training:

a. nature of illness or disability, including symptoms and behavior;
b. pharmacology;
c. potential array of services for the population;
d. building natural support systems;
e. family dynamics;
f. developmental life stages;
g. crisis management;
h. first aid/CPR;
i. signs and symptoms of mental illness, alcohol and drug addiction, mental retardation/developmental disabilities and head injuries;
j. recognition of illegal substances;
k. monitoring techniques;
l. advocacy;
m. behavior management techniques;
n. value clarification/goals and objectives;
o. available community resources;
p. accessing special education services;
q. cultural diversity;
r. pregnancy and prenatal care;
s. health management;
t. team building/interagency collaboration;
u. transition/closure;
v. age and condition-appropriate preventive health care;
w. facilitating team meetings;
x. computers;
y. stress and time management;
z. legal issues.

Each case management supervisor must complete 40 hours of training a year, at a minimum. In addition to the required and suggested topics for case managers, the following are suggested topics for supervisory training:

a. professional identification/ethics;
b. process for interviewing, screening, and hiring of staff;
c. orientation/inservice training of staff;
d. evaluating staff;
e. approaches to supervision;
f. managing caseload size;
g. conflict resolution;
h. documentation;
i. time management;

The required orientation and training for case managers and supervisors described above must be documented in the employee's personnel record including: dates and hours of specific training, trainer or presenter's name, title, agency affiliation or qualification, other sources of training and orientation/training agenda.

Training-Infants and Toddlers with Special Needs. A minimum of eight hours of orientation for new family service coordination staff must be ChildNet specific training as defined by the Department of Education. A minimum of 24 additional hours of training must be provided to new family service coordinators hired in the first 90 days of employment. This training must cover advanced subjects as defined by the Department of Education in addition to the subjects listed above. Initial training specific to ChildNet must be arranged and/or coordinated by the Regional Infant/Toddler Coordinator. Specific ChildNet training content must be approved by a sub-committee of the State Interagency Coordinating Council. Advanced training in specific subjects must be satisfactorily completed prior to the case manager/family service coordinator assuming those duties. Ongoing annual training is the responsibility of the family service coordination agency.

New family service coordination supervisors must satisfactorily complete a minimum of 40 hours of family service coordination training before assuming supervisory duties for this target population. Experienced supervisors must also complete a minimum of 40 hours per calendar year on advanced ChildNet specific subjects defined by the Department of Education.

Mandatory Medicaid Training. Enrolled case management agencies must ensure that all case management staff satisfactorily complete DHH provider required training on case management policies and procedures contained on this document and the *DHH Case Management Provider Manual.*

C. Supervision. Each case management agency must have and implement a written plan for supervision of all case management staff. Face-to-face supervision must occur at least one time per week per case manager for a minimum of one hour per week. Supervisors must review at least 10 percent of each case manager's case records each month for completeness, compliance with these standards, and quality of service delivery. Case managers must be evaluated at least annually by their supervisor according to written provider policy on evaluating their performance. Supervision of individual staff must include the following:

a. direct review, assessment, problem solving, and feedback regarding the delivery of case management services;

b. teaching and monitoring of the application of consumer centered principles and practices;

c. assuring quality delivery of services;

d. managing assignment of caseloads; and

e. arranging for training as appropriate.

The case manager supervisor must utilize by a combination of more than one of the following means:

a. individual, face-to-face sessions with staff to review cases, assess performance and give feedback;

b. group face-to-face sessions with all case management staff to problem solve, provide feedback and support to case managers;

c. sessions in which the supervisor accompanies a case manager to meet with consumers; The supervisor assesses, teaches, and gives feedback regarding the case managers's performance related to the particular consumer.

Each supervisor must maintain a file on each case manager supervised and hold supervisory sessions on at least a weekly basis. The file on the case manager must include, at a minimum:

a. date and content of the supervisory sessions; and

b. results of the supervisory case review which shall address, at a minimum: completeness and adequacy of records; compliance with standards; and, effectiveness of services.

Each case management supervisor must not supervise more than five full-time case managers or a combination of full-time case managers and other human service staff. A supervisor may carry one-fifth of a caseload for each case manager supervised less than five supervisees. If the supervisor carries a caseload, he or she must be supervised by an individual who meets the supervisor qualifications in Section A above.

D. Caseload Size Standards. Each full-time case manager is subject to a maximum caseload of consumers as indicated below:

	Case Weight
Infants and toddlers with special needs	351.14
Developmentally disabled (age 3 and older)	45.888
High risk pregnant women	60.666
HIV infected	45.888
Seriously mentally ill	251.60
Fragile elderly	45.888

Mixed caseloads are those where a case manager serves at least five consumers from a second target population or five waiver participants. For caseloads containing consumers who are seriously mentally ill in addition to those who are developmentally disabled or are infants and toddlers with special needs, the maximum caseload is 35. For other "mixed" caseloads, the number of cases must be likewise prorated.

E. Consumer Eligibility Requirements for Targeted Populations. Case management providers must ensure that consumers of Medicaid funded targeted case management services are Medicaid eligible and meet the additional eligibility requirements specific to the targeted or waiver population group. The eligibility requirements for each targeted and waiver group are listed below. With respect to infants and toddlers with special needs, this determination is made through the Multi-disciplinary Evaluation (MDE) process and is not the responsibility of the case management/family service coordination agency. Also, the service plan for case management services provided to mentally retarded/developmentally disabled individuals and infants and toddlers with special needs is subject to prior authorization by the Medicaid agency or its designee. Providers are required to participate in provider training and technical assistance as required by the Medicaid agency or its designee.

1. Infants and Toddlers with Special Needs

a. a documented established medical condition determined by a licensed medical doctor. In the case of a hearing impairment, licensed audiologist or licensed medical doctor must make the determination; OR

b. a developmental delay in one or more of the following areas:

(1) cognitive development;

(2) physical development, including vision and hearing eligibility must be based on a documented diagnosis made by a licensed medical doctor (vision) or a licensed medical doctor or licensed audiologist (hearing);

(3) communication development;

(4) social or emotional development;

(5) adaptive development;

The determination of a developmental delay must be made in accordance with applicable federal regulations and ChildNet policies and procedures.

2. Developmentally Disabled Children Ages 3 Years and Older and Adults must meet the following definition of *developmental disability*:

a. a severe chronic disability of a person which is attributable to: mental retardation, cerebral palsy, autism or epilepsy; OR any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, or requires treatment or services similar to those required for these persons; AND

b. which is manifested before the person reaches age 22; AND

c. which is likely to continue indefinitely; AND

d. which results in substantial functional limitations in three or more of the following areas of major life activities. Substantial functional limitation means more than two standard deviations below the mean obtained by assessment with one or more standardized evaluation instruments which measure the following areas of major life activities:

(1) self care;

(2) understanding and use of language;

(3) learning;

(4) mobility;

(5) self-direction;

(6) capacity for independent living; AND

e. the consumer must require and is unable to access services from multiple services providers, except in the instance of consumers eligible for waiver services; AND

f. the consumer is at risk of becoming homeless or in need of protection from harm due to environmental or life circumstances, need for supervision, or potential threat of abuse or neglect; OR the consumer has been institutionalized, is at risk of becoming institutionalized or would otherwise require ICF/MR level of care.

3. High-Risk Pregnant Women

a. Pregnancy must be verified by a licensed physician, licensed primary nurse associate, or certified nurse midwife;

b. Reside in the metropolitan New Orleans area including Orleans, Jefferson, St. Charles, St. John and St. Tammany parishes;

c. Be determined high risk based on a standardized medical risk assessment. A *medical risk assessment (screening)* must be performed by a licensed physician, a licensed primary nurse associate, or a certified nurse-midwife to determine if the patient is high risk. A pregnant woman is considered high risk if one or more risk factors are indicated on the form used for risk screening. Providers of medical risk assessment must use the standardized Risk Screening Form approved DHH.

d. Must require services from multiple health, social, informal and formal service providers and is unable to access the necessary services.

4. HIV Infected

a. Written verification of HIV infection by a licensed physician or laboratory test result is required.

b. The *adult* consumer must have reached, as documented by a physician, a level 70 on the Karnofsky scale (or cares for self but is unable to carry on normal activity or do active work) at some time during the course of HIV infection.

c. The *pediatric* consumer must display symptoms of illness related to HIV infection. All consumers must require services from multiple health, social, informal and formal service providers and is unable to access the necessary services.

5. Seriously Mentally Ill

a. *Adults 18 years and older* must meet all of the following criteria for (1), (2), (3) and (4) for serious mental illness (SMI):

(1) Age: 18 years or older; and

(2) Diagnosis: severe non-organic mental illnesses including, but not limited to schizophrenia, schizoaffective disorders, mood disorders, and severe personality disorders, that substantially interfere with a person's ability to carry out such primary aspects of daily living as self-care, household management, interpersonal relationships and work or school; and

(3) Disability: impaired role functioning, caused by mental illness, as indicated by at least two of the following functional areas: unemployed or has markedly limited skills and a poor work history, or if retired, is unable to engage in normal activities to manage income; employed in a sheltered setting; requires public financial assistance for out-of-hospital maintenance (e.g., SSI, and/or is unable to procure such without help, does not apply to regular retirement benefits); severely lacks social support systems in the natural environment, (e.g., no close friends or group affiliations, lives alone, or is highly transient); requires assistance in basic life skills, (e.g., must be reminded to take medicine, must have transportation arranged for them, needs assistance in household management tasks); exhibits social behavior which results in demand for intervention by the mental and/or judicial/legal system; and

(4) Duration: must meet at least one of the following indicators of duration: psychiatric hospitalizations of at least six months in the last five years (cumulative total); two or more hospitalizations for mental disorders in the last twelve-month period; a single episode of continuous structural supportive residential care other than hospitalization for a duration of at least six months; a previous psychiatric evaluation indicating a history of treatment for severe psychiatric disability of at least six months duration.

b. *Children/youth (under age 18) with emotional/behavioral disorders* is defined as follows: behavioral or emotional responses so different from appropriate age, cultural, or ethnic norms that they adversely affect performance (including academic, social, vocational or personal skills); a disability which is more than a temporary, expected response to stressful events in the environment, is consistently exhibited in two different settings and persists despite individualized intervention within general education and other settings. Emotional and behavioral disorders can co-exist with other disabilities.

The following criteria are being established for children/youth with emotional/behavioral disorders and requires that (1), (2), and (3) described below, be met before someone can be described as having an emotional/ behavioral disorder. For the purposes of eligibility for Medicaid case management services, there must be a diagnosis as contained in section (2) below, and, a disability as described in section (3) and, a duration of impairment or patterns of inappropriate behavior which has persisted for at least three months and will persist for at least a year.

(1) Age: under age 18; and

(2) Diagnosis: meets one of the following criteria which operationalize the above definition:

(a) exhibits seriously impaired contact with reality, and severely impaired social, academic, and self-care functioning, whose thinking is frequently confused, whose behavior may be grossly inappropriate and bizarre, and whose emotional reactions are frequently inappropriate to the situation; or

(b) manifest long-term patterns of inappropriate behaviors, which may include but are not limited to aggressiveness, anti-social acts, refusal to accept adult requests or rules, suicidal behavior, developmentally inappropriate inattention, hyperactivity, or impulsiveness; or

(c) experience serious discomfort from anxiety, depression, or irrational fears and concerns whose symptoms may include but are not limited to serious eating and/or sleeping disturbances, extreme sadness, suicidal ideation, persistent refusal to attend school or excessive avoidance of unfamiliar people, maladaptive dependence on parents, or non-organic failure to thrive; or

(d) have a DSM-III-R (or successor) diagnosis indicating a severe mental disorder, such as, but not limited to psychosis, schizophrenia, major affective disorders, reactive attachment disorder of infancy or early childhood (non-organic failure to thrive) or severe conduct disorder. This category does not include children/youth who are socially maladjusted unless it is determined that they also meet the criteria for emotional/behavior disorders; and

(3) Disability: there is evidence of severe, disruptive and/or incapacitating functional limitations of behavior characterized by at least two of the following: inability to routinely exhibit appropriate behavior under normal circumstances; tendency to develop physical symptoms or fears associated with personal or school problems; inability to learn or work that cannot be explained by intellectual, sensory, or health factors; inability to build or maintain satisfactory interpersonal relationships with peers and adults; a general

pervasive mood of unhappiness or depression; conduct characterized by lack of behavioral control or adherence to social norms which is secondary to an emotional disorder. If all other criteria are met, then "conduct disorders" are eligible; and

(4) Duration: impairment or patterns of inappropriate behavior must have persisted for at least three months and will persist for at least a year.

6. Frail Elderly. The consumer must be a participant in the Home Care for the Elderly waiver.

F. Description of Case Management Services/Provider Responsibilities. The definition of *case management* adopted by the department is "services provided by qualified staff to the targeted or waiver population to assist them in gaining access to the full range of needed services including medical, social, educational, and other support services." Targeted and waiver case management services consists of intake, assessment, service planning, linkage/service coordination, monitoring/follow-up, reassessment, and transition/closure. The department utilizes a broker model of case management in which consumers are referred to other agencies for specific services they need. These services are determined by professional assessment of the consumer's needs and provided according to a comprehensive individualized written service plan. All case management services must be provided by qualified staff as defined in Section A above. The provider must ensure that there is no duplication of payment, that there is only one case manager for each eligible consumer and that the consumer is not receiving other targeted case management services from any other provider.

The required core elements of targeted or waiver case management services and provider responsibilities which all Medicaid enrolled case management agencies must comply with are described below:

1. Case Management Intake. *Intake* is defined as the determination of eligibility and need for targeted case management services. Intake is the entry point into case management. The purpose of intake is to gather baseline information to determine the consumer's need, appropriateness, eligibility and desire for case management. The case management provider must have written eligibility criteria for case management services provided by the agency. The required procedures of intake screening are:

a. interview the consumer within *three working days* of receipt of a referral, preferably face-to-face;

b. determine if the consumer is currently Medicaid- eligible;

c. determine if the consumer is eligible for services by virtue of the eligibility requirements of the target population described in Section B above;

d. determine if the consumer's needs require case management services;

e. inform the family of procedural safeguards, rights and grievance/appeal procedure and which includes the following:

(1) determine if the consumer freely accepts case management as optional;

(2) provide the consumer freedom of choice of available targeted case management providers as well as case managers. Advise the consumer of his right to change case management providers and case managers;

(3) provide the consumer freedom of choice of available service providers. The consumer must sign a standardized intake form to verify the above procedural safeguards;

f. obtain signed release form(s) from the consumer/guardian.

Intake activities performed solely to determine eligibility and need for targeted case management are not billable to Medicaid (unless they are performed as part of the case management assessment process and the consumer meets the eligibility requirements for the target or waiver population.

The above general case management intake procedures are applicable for all targeted and waiver groups. Additional or other procedures for specific targeted or waiver groups are delineated below.

Intake for Infants and Toddlers with Special Needs. *Intake for infants and toddlers with special needs* is defined as a comprehensive interagency multi-disciplinary, ongoing process which ensures that eligible children are appropriately identified, located, referred and evaluated for early intervention services. The child search coordinator in the local education agency is the single point of entry into ChildNet. The child search coordinator is responsible for completion of the following intake procedures:

a. upon receipt of a referral, the child search coordinator must assist the family in identifying and choosing an enrolled family service coordinator provider to assist in the MDE process. Referrals received directly by a family service coordination provider must be immediately referred to the appropriate child search coordinator;

b. the child search coordinator must provide the family freedom of choice to select an enrolled family service coordination provider, and advise the family of the right to change family service coordinator provider agencies, family service coordinators and other service providers;

c. the child search coordinator must advise the family of their procedural safeguards and provide them with a copy of their rights under ChildNet.

Intake for High Risk Pregnant Women. Intake must include a standardized medical risk assessment described in Section E3 above.

Intake for Seriously Mentally Ill. All case management services to seriously mentally ill adults and children are subject to prior authorization by the department including eligibility of the consumer for the

target population. The case management provider must submit certain required information including the CAMIS Data Form to enable the regional office to certify that the consumer meets the target population definition. If the consumer does not meet the target population definition, written notification will be sent to the consumer.

Intake for Frail Elderly. Intake procedures for waiver services are described in the appropriate *Waiver Provider Manual*.

2. Case Management Assessment. *Assessment* is defined as the process of gathering and integrating formal/professional and informal information concerning a consumer's goals, strengths, and needs to assist in the development of a comprehensive, individualized service plan. The purpose of assessment is to establish a service plan and contract between the case manager and consumer. The following areas must be addressed in the assessment when relevant: identifying information; medical/physical; psychosocial/ behavioral; developmental/intellectual; socialization/recreational; financial; educational/vocational; family functioning; personal and community support systems; housing/physical environment; and status of other functional areas or domains.

Providers may be required to use standardized assessment instruments for certain targeted populations. The assessment must identify the consumer's strengths, needs and priorities. The assessment must be conducted by the case manager through in-person contact, individualized observations and questions with the consumer and, where appropriate, in consultation with the consumer's family and support network, other professionals, and service providers. The assessment must identify areas where a professional evaluation is necessary to determine appropriate services or interventions. The case manager must arrange for any necessary professional/clinical evaluations needed to clearly define the consumer's specific problem areas. Authorization must be obtained from the consumer/guardian to secure appropriate services.

The assessment must be initiated as soon as possible, preferably within *seven calendar days* of receipt of the referral and must be completed no later than *30 days* after the referral for case management services. A *face-to-face interview* with the consumer is required as part of the assessment process. The initial assessment interview with the consumer must be conducted in the consumer's home to accurately assess the actual living conditions and health and mental status of the consumer unless this is not the consumer's preference or there are genuine concerns regarding safety. If the interview cannot be conducted in the consumer's home, an alternative setting in the consumer's community must be chosen jointly with the consumer and documented in the case record. All assessments must be written, signed, dated, and documented in the case record.

Assessments performed on children in the custody of the Office of Community Services(OCS) or Office of Youth Development(OYD) must actively involve the assigned foster care worker or probation officer and must be approved by the agency with legal custody of the child. Assessments performed on consumers in the custody of the Office of Developmental Disabilities (OCDD) must actively involve the assigned regional office OCDD staff and must be approved by OCDD.

The above general case management assessment procedures are applicable for all targeted and waiver groups. Additional procedures for specific targeted or waiver groups are delineated below:

Assessment for Infants and Toddlers with Special Needs. The child search coordinator is responsible for ensuring all the components of the assessment/multi-disciplinary evaluation (MDE) are fulfilled within the required timeliness. In addition, the child search coordinator must coordinate with the family service coordinator to ensure the development of the initial Individualized Family Service Plan within the required 45 day time lines. The case manager/family service coordinator is responsible for assisting the family through the multi-disciplinary evaluation process including the following:

a. informing the family of the steps involved in the MDE process, explaining their rights and procedural safeguards and securing their participation;

b. reviewing relevant medical information and prior evaluations;

c. coordinating the performance of identified or necessary evaluations and KIDMED screenings and immunizations and an examination by a licensed physician to ensure timely completion of the MDE and IFSP;

d. identifying or coordinating the identification of the family's concerns, priorities and resources;

The MDE must include the following:

a. a review of pertinent records related to the child's current health status and medical history;

b. results of a KIDMED screening or documented referral for KIDMED screening;

c. an evaluation of the child's level of functioning in each of the following developmental areas: cognitive development, physical development, including vision and hearing (by a licensed physician or hearing by a licensed audiologist); communication development; social or emotional development; and adaptive development;

d. an assessment of the child's strengths and needs and the identification of appropriate early intervention services to meet those needs; and

e. with family consent, the family's identification of their concerns, priorities and resources related to enhancing the development of their child;

f. be signed and dated by multi-disciplinary team participants.

Assessment of Developmentally Disabled Children Three Years and Older and Adults

a. Comprehensive Strengths Assessments. The case manager must complete this standardized strengths assessment form in a face-to-face interview with the consumer. The assessment must identify current status in identified areas of community living, the desired outcomes, as well as strategies which have worked in the past to meet the needs or desired outcomes. The strengths assessment must also include a summary paragraph of the need for case management services, identifying current needs and factors by history which emphasize the need for services.

b. CAMIS Initial Assessment

Assessment for Seriously Mentally Ill. Upon approval of the consumer's eligibility for the target population, the regional office will notify the provider of authorization to submit a completed assessment and service plan. A unique authorization number will be issued to the provider which must be used to bill Medicaid upon completion of the assessment and the service plan. The provider must submit the following properly completed assessment documents and service plan forum to the regional office for approval as soon as possible but no later than 30 calendar days from the date of authorization:

a. Comprehensive Strengths Assessment. The case manager must complete this standardized strengths assessment form in a face-to-face interview with the consumer. The assessment must identify current status in identified areas of community living, the desired outcomes, as well as strategies which have worked in the past to meet the needs or desired outcomes. The strengths assessment must also include a summary paragraph of the need for case management services, identifying current needs and factors by history which emphasize the need for services.

b. CAMIS Initial Assessment

Assessment for High Risk Pregnant Women. Assessment of pregnant women is a multi-disciplinary evaluation of the high risk patient to identify factors that may adversely affect health status. Professionals from nursing, nutrition and social work disciplines working as a team must each evaluate the consumer and family needs through interactions and interviews. Each professional assessment must reflect the identified areas for counseling, intervention and follow up services. The nursing, nutritional, and psychosocial assessments must be documented on standardized forms approved by the department. Assessments must be completed within *14 calendar days* after the risk assessment is completed or receipt of the referral. There may be extenuating circumstances with certain patients that may hinder compliance with this time frame for assessment.

The case manager is responsible for assisting the family through the multi-disciplinary evaluation process including the following:

a. coordinating the performance of identified or necessary evaluations to ensure timely completion in preparation for the multi-disciplinary team staffing;

b. identifying or coordinating the identification of the consumer's concerns, priorities and resources.

A home assessment must be completed by the case manager as part of the initial assessment. If a home visit is refused by the consumer/guardian or there are genuine concerns regarding safety, an alternative setting in the consumer's community may be chosen jointly with the consumer and documented in the case record.

Assessment for Frail Elderly. Assessment procedures for waiver services are described in the appropriate *Waiver Provider Manual.*

3. Case Management Service Planning. *Service planning* is defined as the development of a written agreement based upon assessment data (which may be multi-disciplinary), observations and other sources of information which reflect the consumer's needs, capacities and priorities and specifies the services and resources required to meet these needs. The service plan must be developed through a collaborative process involving the consumer, family, case manager, other support systems and appropriate professionals and service providers. It should be developed in the presence of the consumer and, therefore, cannot be completed prior to a meeting with the consumer. The consumer, case manager, support system and appropriate professional personnel must be directly involved and have agreed to assume specific functions and responsibilities.

The service plan must be completed within *45 calendar days* of the referral for case management services. The consumer must be informed of his or her right to refuse a service plan after carefully reviewing it. The service plan must be signed and dated by the consumer and the case manager. Although service plans may have different formats, all plans must incorporate all of the following required components:

a. statement of prioritized long-range goals (problems or needs) which have been identified in the assessment;

b. one or more short-term objectives or expected outcomes linked to each goal that is to be addressed in order of priority;

c. specification of action steps, services or interventions planned, and payment mechanism, if applicable;

d. assignment of individual responsibility for goal accomplishment; and

e. time frames for completion or review.

The service plan must document frequency and/or intensity of contacts between the consumer and case manager, service providers and others, the persons to be contacted and whether the visits must to be to the consumer's place of residence or to another location, such as a service delivery site. Each service plan must be written and kept in the consumer's record. The assessment and service plan must be completed prior to providing ongoing case management services.

The above general case management service planning procedures are applicable for all targeted and waiver groups. Additional procedures for specific targeted or waiver groups are delineated below.

Service Planning for Infants and Toddlers with Special Needs. The family service coordinator's responsibilities in the Individual Family Service Plan (IFSP) must include all of the following:

a. convening a meeting to develop the IFSP within 45 calendar days of referral;

b. attending the IFSP meeting;

c. ensuring that the IFSP meeting is conducted in settings and at times that are convenient to families; in the native language of the family or other mode of communication used by documentation to the regional office within prescribed time lines in accordance with Office of Mental Health procedures.

Service Planning for Frail Elderly. Service planning procedures for waiver services are described in the appropriate Waiver Provider Manual.

4. Case Management Linkage. *Linkage* is defined as the implementation of the service plan involving the arranging for a continuum of both informal and formal services. After obtaining authorization from the consumer, the case manager must contract with the direct service providers or direct the consumer to contact the service providers, as appropriate. The case manager must contract with the consumer for formal and informal services and supports to be arranged. Attempts must be made to meet service needs with informal service providers as much as possible. The responsibilities of the case manager in service coordination are:

a. translating assessment findings into services;

b. determining which services and connections are needed;

c. being aware of community resources (Food Stamps, SSI, Medicaid, etc.);

d. exploration of both formal and informal services for consumers;

e. communicating and negotiating with service providers;

f. training and support of the consumer in the use of personal and community resources identified in the service plan;

g. linking consumers through referrals to services that meet their needs as identified in the service plan; and

h. advocacy on behalf of the consumer to assist them in accessing appropriate benefits or services.

5. Case Management Follow-Up/Monitoring. *Follow-up or Case Management Monitoring* is defined as the follow-up mechanism to assure applicability of the service plan. The purpose of monitoring/follow-up contacts made by the case manager is to determine if the services are being delivered as planned, and/or services adequately meet consumer needs and to determine effectiveness of the services and the consumer's satisfaction with them.

The consumer must be contacted within the first *10 working days* after the initial service plan is completed to assure appropriateness and adequacy of service delivery. Thereafter, face-to-face follow up visits must be made with the consumer/guardian at least monthly as part of the linkage and monitoring follow-up process, or more frequently as dictated by the service plan or determined by the needs of the consumer/guardian. In addition, visits must be made to consumer's home on a quarterly basis, at a minimum. If the consumer refuses home visits or there are genuine concerns regarding safety, an alternative setting in the consumer's community may be chosen jointly with the consumer.

The case manager must communicate regularly by telephone, in writing and in face-to-face meetings and home visits with the consumer/guardian, professionals and service providers involved in the implementation of the service plan. The nature of these follow-up contacts (i.e. telephone, home visit) and the individuals contacted be determined by the status and needs of the consumer, as identified in the service plan and determined by the case manager.

Through this activity, the case manager must determine whether or not the service plan is effective in meeting the consumer's needs and identify when changes in the consumer's status occur, necessitating a revision in the service plan. Reassessment is required when a major change in status of the consumer/guardian occurs.

Monitoring of services provided includes the following:

a. following up to assure that the consumer actually received the services as scheduled;

b. assuring that consumer/consumer's family is able and willing to comply with recommendations of service providers;

c. measuring progress of consumer in meeting service plan goals and objectives and determining whether the services adequately address the consumer's needs.

Monitoring information must be obtained by the case manager through direct observation and direct feedback. The case manager must gather information from direct service providers for monitoring purposes. The case manager must obtain verbal or written service reports from direct service providers.

The above general case management service planning procedures are applicable for all targeted and waiver groups. Additional procedures for specific targeted or waiver groups are delineated below.

Follow-Up/Monitoring for High Risk Pregnant Women. The case manager must maintain at least weekly face-to-face or telephone contact with the consumer/guardian, family, informal and/or formal providers to implement the service plan and follow up/ monitoring service provision and the consumer's progress in accordance with the service plan.

Follow-Up/Monitoring for Seriously Mentally Ill. The case manager must have at least weekly face-to-face or telephone contact with the consumer/guardian.

6. Case Management Reassessment. *Reassessment* is defined as the process by which the baseline assessment is reviewed. It provides the opportunity to gather information for evaluating and revising the overall service plan. After the initial assessment is completed and initial service plan is implemented, the consumer's needs and progress toward accomplishing the goals listed in the service plan goals must be reevaluated on a routine basis or when a significant change in status or needs occurs. Reassessment is accomplished through interviews and periodic observations.

The purpose of reassessment is to determine if the consumer's condition, situation or needs have significantly changed and to evaluate the effectiveness of the service plan in meeting predetermined goals. If indicated, the identified needs, short-term goals or objectives, services, and/or service providers must be revised. A schedule for reassessing and modifying the initial goals and service plans must be part of the initial workup. Reassessment and review and/or updating of the service plan must be done at intervals of no less than 90 calendar days. If there is a minor change in the service plan, the case manager must revise the plan and initial and date the change. More frequent reassessments may be required, depending upon the consumer's situation.

At least every *six months*, a complete review of the service plan must be done to assure that goals and services are appropriate to the consumer's needs identified in the assessment/reassessment process. A home-based reassessment must be done on at least an *annual* basis unless this is not the consumer's preference or there are genuine concerns regarding safety. If the reassessment cannot be conducted in the consumer's home, an alternative setting in the consumer's community must be chosen jointly with the consumer and documented in the case record.

The above general case management reassessment procedures are applicable for all targeted and waiver groups. Additional procedures for specific targeted or waiver groups are delineated below.

Reassessment for Infants and Toddlers with Special Needs. Ongoing assessment is a component of the IFSP process. A review of the IFSP must be conducted at least every six months, or more often if conditions warrant, or if the family requests a review to determine the following:

a. the degree to which progress is being made toward achieving the outcomes; and

b. whether modifications or revisions of the outcomes or services are necessary.

The review may be carried out by a meeting or by other means that is acceptable to the families and other participants.

An annual meeting must be conducted to evaluate the IFSP and, as appropriate, revise the IFSP. The results of any ongoing assessments of the child and family, and any other pertinent information must be used in determining what early intervention services are needed and will be provided.

7. Case Management Transition/Closure. Discharge from case management must occur when the consumer no longer needs or desires the services, or becomes ineligible for them. The closure process must ease the transition to other services or care systems. When closure is deemed appropriate, the consumer must be notified immediately so that appropriate arrangements can be made. The case manager must complete a final reassessment identifying any unresolved problems or needs and discussing with the consumer methods of arranging for their own services.

Criteria for closure include but are not limited to the following:

a. resolution of the consumer's service needs with low probability of recurrence;

b. consumer requests termination of services;

c. death;

d. permanent relocation out of the service area;

e. long term admission to a hospital, institution or nursing facility;

f. does not meet the criteria for the case management established by the funding source (e.g., Medicaid or the Program Office);

g. the consumer requires a level of care beyond that which can safely be provided through case management;

h. the safety of the case manager is in question; or

i. noncompliance.

All cases which do not have an active service plan and necessary linkage or monitoring activities must be closed. Infants and toddlers eligible under ChildNet are no longer eligible for Medicaid funded case management services if the only service in the IFSP is case management/family service coordination.

8. Procedures for Changing Providers. A consumer may freely change case management providers or case managers or terminate services at any time. DHH maintains a listing of enrolled and approved case management providers for each target and waiver population which consumers and service providers may access for referral purposes. Once the consumer has chosen a new case management provider, the new provider must complete the standardized "Provider Change Notification" form), obtain the consumer's written consent and forward the original change form to the previous case management provider. Upon receipt of the completed form, the previous provider must send copies of the following information as required by licensing standards within 10 working days:

a. most current service plan;
b. current assessments on which service plan is based;
c. number of services used in the calendar year;
d. current and previous quarter's progress notes.

The new provider must bear the cost of copying which cannot exceed the community's competitive copying rate. The previous provider may not provide case management services after the date the notification is received.

The above general procedures for changing case management providers are applicable for all targeted and waiver groups except as otherwise specified for particular groups delineated below.

Procedures for Changing Family Service Coordination Providers-Infants and Toddlers with Special Needs. If a family chooses to change family service coordination agencies or a change is necessary for any reason, the following procedures will be followed:

a. the family will be referred back to the child search coordinator. This referral can be made by the family, the current family service coordinator, or other service providers;

b. the child search coordinator will provide the family with the official list of family service coordination providers and the freedom of choice form;

c. the child search coordinator will review the family's rights under ChildNet with the family including the right to change family service coordinators or agencies;

d. the child search coordinator or the family, if the family chooses, will notify the newly selected agency;

e. the child search coordinator will notify the old agency at termination;

f. after receiving written informed parental consent, the new agency will request records from the previous agency. The previous agency will make these records available within 10 working days of receipt of the request.

III. General Provisions

A. Documentation. The provider must keep sufficient records to document compliance with licensing and Medicaid case management requirements for the target population served and provision of case management services. Separate case management records must be maintained on each consumer which fully document services for which Medicaid payments have been made. The provider must maintain sufficient documentation to enable the Medicaid Program to verify that each charge is due and proper prior to payment. The provider must make available all records which the Medicaid Program finds necessary to determine compliance with any federal or state law, rule, or regulation promulgated by the Medicaid Program, DHH or DHHS or other applicable state agency.

The consumer's case record must consist of the following information, at a minimum:

1. Medicaid eligibility information;
2. documentation verifying that the consumer meets the requirements of the targeted population;
3. a copy of the standardized procedural safeguard form signed by the consumer;
4. copies of any professional evaluations and other reports used to formulated the service plan;
5. case management assessment;
6. progress notes;
7. service logs;
8. copies of correspondence;
9. at least six months of current pertinent information relating to services provided. (Records older than six months may be kept in storage files or folders, but must be available for review.);
10. if the provider is aware that a consumer has been interdicted, a statement to this effect must be noted.

Service Logs. Service logs are the means for recording units of billable time. There must be case notes corresponding to each recorded time of case management activity. The notes should not be a narrative with every detail of the circumstances. Service logs must reflect service delivered, the "paper trail" for each service billed. Logs must clearly demonstrate allowable services billed. Services billed must clearly be related to the current service plan. Billable activities must be of reasonable duration and must agree with the billing claim. All case notes must be clear as to who was contacted and what allowable case management activity took place. Use of general terms such as "assisted consumer to" and "supported consumer" do not constitute adequate documentation.

Logs must be reviewed by the supervisor to insure that all billable activities are appropriate in terms of the nature and time and documentation is sufficient. Federal requirements for documenting case management claims require the following information must be entered on the service log to provide a clear audit trail:

1. name of consumer;
2. name of provider and person providing the service;
3. names and telephone numbers of persons contacted;
4. start and stop time of service contact and date of service contact;
5. place of service contact;
6. purpose of service contact;
7. content and outcome of service contact.

Progress Notes. Progress notes are the means of summarizing billable activities, observations and progress toward meeting service goals in the case management record. Progress notes must:

1. be clear as to who was contacted and what case management activity took place for each recorded time of case management. It must be clear why that time period was billed;
2. record activities and actions taken, by whom, progress made and indicate how goals in the service plan are progressing;
3. document delivery of each service identified on the service plan;
4. record any changes in the consumer's medical condition, behavior or home situation which may indicate a need for a reassessment and service plan change;
5. be legible, as well as legibly signed, including functional title, and fully dated; and
6. be complete, entered in the record preferably *weekly* but at least *monthly* and signed by the primary case manager.

Progress notes must be recorded more frequently (weekly) when there is frequent activity or significant changes occur in the consumer's service needs and progress. Quarterly progress notes are required in addition to the minimum monthly recording A summary must also be entered in the consumer's record when a case is transferred or closed.

The organization of individual case management records on consumers and location of documents within the record must conform with state licensing standards and be consistent among records. All entries made by staff in consumer records must be legible, fully dated, legibly signed and include the functional title of the individual. Any error made by the staff in a consumer's record must be corrected using the legal method which is to draw a line through the erroneous information, write "error" by it and initial the correction. Correction fluid cannot be used in consumer records.

Providers must make all necessary consumer records available to appropriate state and federal personnel at all reasonable times. Providers must always safeguard the confidentiality of consumer information. Under no circumstances should providers allow case management staff to take records home. The case management agency can release confidential information only under the following conditions:

1. by court order; OR
2. by the consumer's written informed consent for release of the information. In cases where the consumer has been declared legally incompetent, the individual to whom the consumer's rights have devolved must provide informed written consent.

Providers must provide reasonable protection of consumer records against loss, damage, destruction, and unauthorized use. Administrative, personnel and consumer records must be retained until records are audited and all audit questions are answered or three years from the date of the last payment, whichever is longer.

B. Reimbursement

1. General Requirements. As with all Medicaid services, payment for targeted or waiver case management services is dictated by the nature of the activity and the purpose for which the activity is performed. All case management services billed must be provided by qualified case managers and meet the definition of *case management*` services provided by qualified staff to the targeted or waiver population to assist them in gaining access to the full range of needed services including medical, social, educational, and other support services. This definition encompasses *assisting eligible consumers* in gaining access to needed services including:

   a. identifying services needed;
   b. linking consumer with the most appropriate providers of services; and
   c. monitoring to ensure needed services are received.

Case management does not consist of the provision of other needed services, but is to be used as a *vehicle* to help an eligible consumer gain access to them. A general rule of thumb for providers to follow is if there is no interaction in person, by telephone or in correspondence on behalf of the consumer, it is most likely not a billable case management activity.

2. Reimbursement Requirements for Infants and Toddlers with Special Needs.

   a. Candidates for case management services must be Medicaid eligible.

   b. Medicaid eligibles must be certified as a member of the targeted populations by the Medicaid agency or its designee.

c. The case management service plan is subject to prior authorization by Medicaid agency or its designee.

d. Providers of case management services are required to participate in provider training and technical assistance as required by the Medicaid agency or its designee.

C. Non-billable Activities. Federal regulations require that the Medicaid Program ensure that payments made to providers do not duplicate payments for the same or similar services furnished by other providers or under other authority as an administrative function or as an integral part of a covered service.

A technical amendment (Public Law 100-617) in 1988 specifies that the Medicaid Program is not required to pay for case management services that are furnished to consumers without charge. This is in keeping with Medicaid's longstanding position as the payer of last resort. With the statutory exceptions of case management services included in Individualized Education Programs (IEPs) or Individualized Family Service Plans (IFSPs) and services furnished through Title V public health agencies, payment for case management services cannot be made when another third party payer is liable, nor may payments be made for services for which no payment liability is incurred.

Time spent in activities which are not a direct part of a contact are not Medicaid reimbursable. Activities that, while they may be necessary, do not result in a service identified in the service plan being provided to the consumer are not reimbursed. The following examples of activities are not considered targeted case management services for Medicaid purposes and are not reimbursable by the Medicaid Program as case management:

1. outreach, case finding or marketing;
2. counseling or any form of therapeutic intervention;
3. developing general community or placement resources or a community resource directory;
4. legislative or general advocacy;
5. professional evaluations;
6. training;
7. providing transportation;
8. telephone calls to a busy number, leaving messages, FAXing or mailing information;
9. travel to a consumer's home for a home visit, and the consumer is not at home so that the visit cannot be held but a note is left;
10. "housekeeping" activities in connection with record keeping. (Recording a contact in the case record at the time service is provided is billable.);
11. in-service training, supervision;
12. discharge planning; EXCEPTION: 10 days (30 days for developmentally disabled waiver participant) before discharge from an inpatient facility to assist the consumer in the transition from inpatient to outpatient status, and in arranging appropriate services and 10 days after institutionalization or hospitalization to arrange for closure of community services;
13. intake screening which takes place prior to and is separate from assessment;
14. general administrative, supervisory or clerical activities;
15. record keeping;
16. general interagency coordination;
17. program planning;
18. Medicaid billing or communications with Medicaid Program;
19. running errands for family (shopping, picking up medication, etc.);
20. accompanying family to appointments or recreational activities, waiting for appointments with family;
21. lengthy interaction to "get acquainted", "provide support" or "hand holding";
22. activities performed by agency staff other than the primary case manager;
23. accompanying another case manager either because of or for safety reasons.

Bobby P. Jindal
Secretary

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